



# ARIZONA BOARD OF OCCUPATIONAL THERAPY EXAMINERS

4205 N. 7<sup>th</sup> Avenue, Suite 305  
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www.ot.az.gov

## APPLICATION FOR LICENSURE AS AN OCCUPATIONAL THERAPIST OR AN OCCUPATIONAL THERAPY ASSISTANT

| CHECK<br>ALL THAT<br>APPLY | INITIAL APPLICATION  | FEE      |
|----------------------------|--|----------|
|                            | <b>APPLICATION FEE</b>   | \$100.00 |
|                            | <b>LICENSE FEE</b>   |          |
|                            | OCCUPATIONAL THERAPIST   | \$135.00 |
|                            | OCCUPATIONAL THERAPY ASSISTANT   | \$70.00  |
|                            | <b>LIMITED PERMIT**</b>  | \$ 35.00 |
|                            | If applying for a limited permit , you must pay the application fee plus the limited permit fee for a total of \$135.00. The limited permit fee will be subtracted from the License fee at the time the applicant passes the NBCOT exam and requests full licensing. |          |
|                            | <b>FINGERPRINT – all applicants must pay this fee.</b>   | \$ 24.00 |
|                            | <b>TOTAL AMOUNT SUBMITTED</b>  |          |

**\*\* Must provide proof of completion of educational requirements**

**PERSONAL INFORMATION (Type or Print)**

|                               |                          |                      |                          |                                 |                          |                 |
|-------------------------------|--------------------------|----------------------|--------------------------|---------------------------------|--------------------------|-----------------|
| <b>Name</b>                   | <b>Last</b>              |                      | <b>First</b>             |                                 | <b>Middle</b>            |                 |
| <b>Other names used</b>       |                          | <b>Maiden</b>        |                          | <b>Also Known As – AKA</b>      |                          |                 |
| <b>Home address</b>           |                          | <b>Number/Street</b> |                          | <b>City</b>                     | <b>State</b>             | <b>Zip code</b> |
| <b>Telephone Number</b>       |                          | <b>Home</b>          | <b>Work</b>              |                                 | <b>Cell</b>              |                 |
| <b>Email address</b>          |                          |                      |                          |                                 |                          |                 |
| <b>Social Security Number</b> |                          |                      |                          | <b>Date of Birth (mm/dd/yy)</b> |                          |                 |
| <b>Place of Birth</b>         |                          | <b>City</b>          | <b>County/Province</b>   |                                 | <b>State/Country</b>     |                 |
| <b>Gender</b>                 | <input type="checkbox"/> | <b>Male</b>          | <input type="checkbox"/> | <b>Female</b>                   | <input type="checkbox"/> |                 |
|                               |                          |                      |                          | <b>US Citizen</b>               | <input type="checkbox"/> | <b>YES</b>      |
|                               |                          |                      |                          | <input type="checkbox"/>        | <b>NO</b>                |                 |

**ATTACH REQUIRED STATEMENT OF CITIZENSHIP AND ALIEN STATUS ALONG WITH SELECTED PROOF OF STATUS.**

**CURRENT EMPLOYMENT (Type or Print)**

|                         |                      |  |                              |              |                 |
|-------------------------|----------------------|--|------------------------------|--------------|-----------------|
| <b>Name of Employer</b> |                      |  | <b>Employer Phone Number</b> |              |                 |
| <b>Employer Address</b> | <b>Number/Street</b> |  | <b>City</b>                  | <b>State</b> | <b>Zip code</b> |

|                                   |  |                     |  |
|-----------------------------------|--|---------------------|--|
| <b>NBCOT Certification Number</b> |  | <b>Date Granted</b> |  |
|-----------------------------------|--|---------------------|--|

**PROFESSIONAL EXPERIENCE AND/OR FIELDWORK:**

List **ALL** employment for the last four (4) years in chronological order, beginning with your present position.

|   |                              |
|---|------------------------------|
| <b>1. Name of Business</b>                | <b>Job Title</b>             |
| <b>Name of Employer</b>                   | <b>Description of Duties</b> |
| <b>Address/Phone Number of Business</b>   | <b>Dates of Employment</b>   |
|   | <b>From:</b> <b>To:</b>      |
| <b>Reason for Resignation/Termination</b> |                              |

|   |   |
|---|---|
| <b>2. Name of Business</b>                | <b>Job Title</b>  |
| <b>Name of Employer</b>                   | <b>Description of Duties</b>                                      |
| <b>Address/Phone Number of Business</b>   | <b>Dates of Employment</b><br><b>From:</b> _____ <b>To:</b> _____ |
| <b>Reason for Resignation/Termination</b> |   |

|   |   |
|---|---|
| <b>3. Name of Business</b>                | <b>Job Title</b>  |
| <b>Name of Employer</b>                   | <b>Description of Duties</b>                                      |
| <b>Address/Phone Number of Business</b>   | <b>Dates of Employment</b><br><b>From:</b> _____ <b>To:</b> _____ |
| <b>Reason for Resignation/Termination</b> |   |

|   |   |
|---|---|
| <b>4. Name of Business</b>                | <b>Job Title</b>  |
| <b>Name of Employer</b>                   | <b>Description of Duties</b>                                      |
| <b>Address/Phone Number of Business</b>   | <b>Dates of Employment</b><br><b>From:</b> _____ <b>To:</b> _____ |
| <b>Reason for Resignation/Termination</b> |   |

## EDUCATIONAL INFORMATION:

List Colleges/Universities attended (List most recent first)

| School Name, City, State, Country | Dates of Attendance<br>From (mm/yy) To (mm/yy) | Date of Graduation | Type of Degree /Certification |
|-----------------------------------|--|--------------------|-------------------------------|
|                                   |  |                    |                               |
|                                   |  |                    |                               |
|                                   |  |                    |                               |
|                                   |  |                    |                               |

## Professional Licenses or Certifications:

List all active and inactive licenses or certifications

| Type of License/Certification<br>Agency Name and Address | Issue Date | Expiration Date | License/<br>Certification<br>Number |
|--|------------|-----------------|-------------------------------------|
|  |            |                 |                                     |
|  |            |                 |                                     |
|  |            |                 |                                     |
|  |            |                 |                                     |

|  |                          |     |                                     |                          |    |
|--|--------------------------|-----|-------------------------------------|--------------------------|----|
| Are the above licenses in good standing? | <input type="checkbox"/> | YES | <input checked="" type="checkbox"/> | <input type="checkbox"/> | NO |
|--|--------------------------|-----|-------------------------------------|--------------------------|----|

|  |                          |     |                                     |                          |    |
|--|--------------------------|-----|-------------------------------------|--------------------------|----|
| If other than Arizona, did your prior state of residence require a license. Name of State: | <input type="checkbox"/> | YES | <input checked="" type="checkbox"/> | <input type="checkbox"/> | NO |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
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|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |
|  |                          |     |                                     |                          |    |

**ALL Questions MUST be answered:**

|   |     |  |    |
|---|-----|--|----|
| 1. Have you ever had any application for any professional license refused or denied by any licensing authority?   | YES |  | NO |
| 2. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?   | YES |  | NO |
| 3. Have you ever voluntarily surrendered any healthcare license?  | YES |  | NO |
| 4. Have you ever had any healthcare license revoked?  | YES |  | NO |
| 5. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? | YES |  | NO |
| 6. Has disciplinary action been taken against you by any licensing agency with regard to any professional license?<br>Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.  | YES |  | NO |
| 7. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?  | YES |  | NO |
| 8. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of any felony, misdemeanor involving moral turpitude (see explanation below)? <b>A “yes” answer is required even if you entered a diversion program.</b>                                      | YES |  | NO |
| 9. Have you ever been charged with or convicted of a violation of any federal or state drug law(s) or rule(s) whether or not a sentence was imposed or suspended?   | YES |  | NO |

**NOTE:** *In the event the response to any of the questions numbered 1 through 9 is “YES”, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s) IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments.*

**\*\*Moral Turpitude** includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

### VERIFICATION BY OATH OR AFFIRMATION

The undersigned verifies that he/she is the person referred to in the foregoing application; that the statements are true in every respect; that he/she has not suppressed any information that would affect this application; that he/she will conform to ethical standards of conduct in the profession of occupational therapy and obey the laws of the State of Arizona and the Rules established by the Board of Occupational Therapy Examiners; that he/she has read and understands that failure to disclose the requested information or disclosure of false information or disclosure of misleading information may constitute fraud and may result in denial of licensure/certification or disciplinary action, up to and including revocation, taken against an issued license or certificate. Failure to disclose the requested information or disclosure of false or misleading information may also result in criminal prosecution.

AND

### AFFIDAVIT OF APPLICANT

I, \_\_\_\_\_, under oath, do promise and swear that if this application is accepted and if I should be granted a license to practice as an occupational therapist or an occupational therapy assistant in this State, I will obey the Laws of the State of Arizona as they relate to the Board of Occupational Therapy Examiners and the associated rules established by the Board of Occupational Therapy Examiners, and maintain the honor and dignity of the profession. I have read these Arizona Revised Statutes and Rules and agree to be held accountable for any actions that may violate these Statutes and Rules.

It is understood and agreed that if I should fail to keep the above agreement, or if I have made any false statements in this application, that my license may be suspended or revoked by the Board at any time. By virtue of this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct, and complete to the best of my knowledge. I hereby authorize the Board of Occupational Therapy Examiners to verify any and all information contained in this application, including information maintained in applicable data banks, and to transmit this information to the licensing authority of the state to which this application is made. I authorize the licensing authority of the state where application is submitted to review state files pertaining to my licensure and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the licensing authority.

I understand that my application is a public record. Further, I authorize all current and previous employers to release all relevant information about my employment to the Board (including moral character competency and reason for termination of employment, if applicable). I further state, under penalty of perjury, that all statements made by me and exhibits attached within this application are true, complete, and accurate.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

State: \_\_\_\_\_

County: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by the affiant, who personally appeared before me.

\_\_\_\_\_  
NOTARY PUBLIC SIGNATURE

My Commission expires: \_\_\_\_\_  
(Official Stamp)